

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1423163-082005

FILED SEP 9 1963

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY WRIGHT	
b. CITY (If outside corporate limits, give TOWNSHIP only) SPRINGFIELD		c. CITY OR TOWN MT. GROVE	
Length of stay in 1b 12 DAYS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If outside, give location) UNKNOWN	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last MINERVA BELLEZORA TURNER			4. DATE OF DEATH Month Day Year AUGUST 22, 1963		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/23/23	9. AGE (last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (City and state or country) MT. GROVE, MO.	
12. CITIZEN OF WHAT COUNTRY USA					
13a. FATHER'S NAME GARDNER DAKE		13b. MOTHER'S MAIDEN NAME ELIZA SANDERS		14. NAME OF HUSBAND OR WIFE JOHN W. TURNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address JAMES G. TURNER; 1130 W. SCOTT	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism		INTERVAL BETWEEN ONSET AND DEATH 5 hrs
DUE TO (b) Fracture of left hip		13 days
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) She fell
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20c. TIME OF INJURY Hour a.m. p.m. 8-19-63	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION mt. Grove	COUNTY mt	STATE mo
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21. I attended the deceased from 8-12-63 to 8-22-63 and last saw her alive on 8-22-63
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Death occurred at 2:30 P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE (Degree or title) Wyates Trotter M.D.	22b. ADDRESS SPRINGFIELD, MISSOURI	22c. DATE SIGNED 8-30-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/26/63	23c. NAME OF CEMETERY OR CREMATORY MT. VALLEY CEMETERY	23d. LOCATION (City, town, or county) MT. GROVE, MISSOURI	(State)
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24. FUNERAL DIRECTOR AYRE-GOODWIN	ADDRESS SPRINGFIELD, MO.	25. DATE RECD. BY LOCAL REG. 9-4-63	26. REGISTRAR'S SIGNATURE Bernie Madley
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 0397

2 1141

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4 1

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8 2

9 9040

10 21

11 114

12 4-0

13

8/23/63

NOV 20 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed B. M. Abbott

Licensed Embalmer No. 5115

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.